Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS IMPAIRMENT EXAM
TRENTON D. WEEKS, DC

Respondent Name
BITCO NATIONAL INSURANCE CO

MFDR Tracking Number
M4-14-1269-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 02/12/2013 I performed an evaluation to determine maximum medical improvement and impairment of the above named claimant. I performed this examination at the request of the injured employee and the treating doctor."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The service in dispute was performed by Dr. Gist. Dr. Gist was not the treating doctor at the time. Dr. Gist was not a referral of the treating doctor at the time. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and to be designed to ensure the quality of medical care and to achieve effective medical cost control."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 12, 2013	CPT Code 99456-NM Designated Doctor Examination – Not at MMI	$350.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §180.22, effective January 9, 2011 requires the treating doctor to coordinate the claimant's health care.
3. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 38-Svcs not provided/authorized by treating doctor.
   - 168-No additional allowance recommended.

- 193-Original payment decision maintained.
- NM-Not at maximum medical improvement.

Issues

Is the disputed service authorized by the treating doctor? Is the requestor entitled to reimbursement?

Findings

The respondent denied reimbursement for CPT code 99456-NM based upon reason code "38." The respondent contends that "The service in dispute was performed by Dr. Gist. Dr. Gist was not the treating doctor at the time. Dr. Gist was not a referral of the treating doctor at the time."

In support of their position, the respondent submitted a copy of a Commission Order report dated February 7, 2013 denying the request to change treating doctors from Dr. Michael Lee Brennan to Dr. Stephen Gist.

28 Texas Administrative Code §180.22(c) states "The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers, as defined in this section."
The Division reviewed the submitted medical bill that indicates the referring doctor was Stephen Gist. Because Dr. Gist was not the treating doctor on the disputed date of service, the referral for MMI/IR examination was not in accordance with 28 Texas Administrative Code §180.22(c). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/19/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.